Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SURGERY SPECIALTY HOSPITALS OF AMERICA S E HOUSTON CAMPUS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-10-3141-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERICAN ZURICH INSURANCE COMPANY Rep Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Provider submitted a bill to Carrier on **April 01, 2009.** On or about **April 27, 2009**, Carrier sent Provider an Explanation of Benefits and included payment in the amount of **$3,473.00**. On **October 29, 2009**, Provider sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the appropriate sections of the fee guideline applicable when Provider does not request separate reimbursement for implantables, specifically, 28 TEX. ADMIN. CODE section 143.403(f)(1). Provider incorrectly calculated the APC value on its Request for Reconsideration when it requested additional reimbursement from the Carrier in the amount of $9,625.62. If calculated pursuant to section 134.403(f)(1)(A), reimbursement for the services provided should be **$12,918.62.** The Carrier is required to reimburse Provider **$12,918.62** pursuant to the Outpatient Fee Guideline, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of **$3,473.00**. Therefore, the Carrier is required to reimburse Provider in the additional amount of **$9,445.62**, plus any and all applicable interest."

Amount in Dispute: $9,445.62

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to this dispute.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
03/24/2009	**Hospital Outpatient Surgical Services**	**Total APC + Outlier: $6,459.31** **Total MAR: $12,918.62** **Respondent Paid: $3,473.00** **Requestor Due: $9,445.62**	$9,445.62	$9,445.62
		Total Due:		$9,445.62

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled *Hospital Facility Fee Guideline – Outpatient***,** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

1. The disputed services were denied or reduced by the insurance carrier based upon:
   Explanation of benefits dated 04/22/09 noted claim reduction codes:
   - 16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REM.
   - 59 — PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

   Explanation of benefits dated 12/09/09 noted claim reduction codes:
   - 16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL

INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REM.

- 59 — PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- 96 — NON COVERED CHARGES.
- W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

2. According to the submitted explanation of benefits dated 04/22/09, the carrier denied reimbursement for the services in dispute based upon claim lacks information which is needed for adjudication. Review of the submitted documentation finds no additional remittance advice remarks codes or explanations describing the information needed for adjudication. Division rule at 28 TAC §133.3 (a) requires that "any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." No documentation was found to support communication of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. This denial reason is not supported. The Division concludes that the respondent has failed to meet the requirements of 28 TAC §133.3 (a). The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

4. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) The submitted documentation does not support that the provider requested separate reimbursement for implantables with the billing.

6. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

7. Reimbursement is calculated as follows:

   The total Medicare facility specific amount including outliers is $6,459.31
   This amount multiplied by 200% = $12,918.62
   Total Maximum Allowable Reimbursement (MAR) is $12,918.62
   This amount less the amount previously paid by the respondent of $3,473.00
   leaves an amount due to the requestor of $9,445.62.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $9,445.62.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031, §413.0311
28 TAC §133.305, §133.307, §134.403

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $9,445.62 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

ORDER:

		February 7, 2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		February 7, 2011
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.